DENTAL BOARD OF CALIFORNIA

Authorization for Release of Dental/Medical Patient Records

Patient Name:_____ Date of Birth:_____

AUTHORIZATION TO OBTAIN INFORMATION: I authorize any physician, dentist, medical practitioner, hospital, clinic or other dental or dental related facility having information available as to diagnosis, treatment and prognosis with respect to any dental or medical condition and/or treatment of me or my minor children to give to the Dental Board of California or its legal representative any and all such information.

I understand that the information obtained under this Authorization will be used by the Dental Board of California or its authorized representative to determine the circumstances leading to this inquiry and all implications related to dental/medical treatment. Any information obtained will not be released by the Dental Board of California or its representative except to persons or organizations performing business or legal services in connection with this inquiry, as may be lawfully required pursuant to subpoena or discovery request, or as I may further authorize.

I agree that a photocopy of this Authorization shall be as valid as the original.
This Authorization shall remain valid until the Dental Board of California completes its review and the proceedings arising out of the investigation.

Patient/Guardian Signature:_____Date:_____